STATE OF DELAWARE – DIVISION OF MOTOR VEHICLES
REPORT OF VISUAL STATUS BY AN OPTOMETRIST OR OPTHALMOLOGIST

NAME OF APPLICANT_____**D.O.B.**_____**D.L.#**_____

ADDRESS_____**DATE**_____

DIVISION LOCATION_____

VISUAL ACUITY	NO R/	WITH R/	
R.E.	20/	20/	☐ CONTACT LENS
L.E.	20/	20/	☐ GLASSES
B.E.	20/	20/	

IS THERE ANY EVIDENCE OF EYE DISEASE OR DEFECTOF STRUCTURE THAT WOULD AFFECT VISUAL PERFORMANCE NOW OR IN THE FUTURE?

WOULD DRIVER'S VISUAL ABILITIES BE IMPROVED BY CORRECTIVE LENS?_____

ARE THEY BEING PRESCRIBED?_____

DESCRIBE ANY FIELD DEFECT:

IN THE CAUSE OF SAFETY, ARE THERE ANY RESTIRCTIONS THAT SHOULD BE IMPOSED ON THE LICNESE? ☐ NO ☐ YES

☐ CORRECTIVE LENSES
☐ DAYLIGHT DRIVING ONLY

Doc. No. 45-07-95-09-01

MV-312

WITH REGARD TO DRIVING, HOW OFTEN SHOULD APPLICANT HAVE VISION CHECKED?

☐ 1 YR. ☐ 2 YR. ☐ 3 YR. ☐ 4 YR.

ARE THERE ANY CIRCUMSTANCES THAT MIGHT BE EXPLAINED TO AID FINAL DISPOSITION OF THIS CASE?

REMARKS:

I HEREBY CERTIFY THAT I'M LICENSED TO PRACTICE

_____ IN THE STATE OF

_____LIC OR REC. NO._____

_____
NAME AND DEGREE – PLEASE PRINT

_____
ADDRESS

_____
SIGNATURE DATE

PRESCRIPTION BLANK OR STATEMENT OF EXAMINING DOCTOR ***MUST*** BE INCLUDED WITH THIS REPORT. MAIL TO EXAMINER AT HIS LOCATION.

(DO NOT RETURN TO APPLICANT)

20/40 -UNRESTRICTED **20/50 - DAYLIGHT DRIVING ONLY** **BELOW 20/50 – LICENSE DENIED**